RESULTS: Within 2 years of incision, excision and anastomosis of intestine, 14.3% of patients had obstruction, 2.6% required an adhesiolysis for obstruction, and 12.9% underwent additional open colorectal or general surgery. After other operations of intestine, 17% of patients had obstruction, 3.1% required an adhesiolysis, and 20.2% underwent additional surgery. After operations of rectum, rectosigmoid and perirectal tissue, 15.3% of patients had obstruction, 5.1% required an adhesiolysis, and 16.4% underwent additional surgery.
CONCLUSIONS: In this study of Medicare patients, bowel obstruction, adhesiolysis for obstruction, and additional abdominal surgery occurred more often after abdominal surgery than previously published.

TPRD3

OUTCOMES OF TREATMENT OF UNCOMPLICATED HYPERTENSION WITH DIHYDROPYRIDINE CALCIUM CHANNEL BLOCKERS

Lenert LA[1], Linde-Zwirble W[2], Newbold III R[2], Korenblat BM[3], Smith ME[3], Pomerantz K[3], Chung KC[3]
[1]Department of Veterans Affairs, San Diego, CA, USA; [2]Health Process Management, Doylestown, PA, USA; [3]Bayer Corporation, Pharmaceutical Division, West Haven, CT, USA

OBJECTIVE: To compare the effectiveness and costs of care for nifedipine-CC and amlodipine when used for initial management of uncomplicated hypertension.
METHODS: A retrospective analysis was conducted using outpatient pharmacy, provider, and hospital discharge claims records of continuously eligible Pennsylvania Medicaid patients started on either drug in 1994 without prescriptions for other anti-hypertensive agents or reported cardiovascular complications in the 8 months prior to initial nifedipine-CC or amlodipine prescription. Comparison of three indicators of change in prescriptions were evaluated to provide information on medication effectiveness. Chi-square tests of association were conducted to evaluate effectiveness indicators while linear regression was utilized to compare costs.
RESULTS: Patients satisfying inclusion/exclusion criteria who received nifedipine-CC ($n = 151$) or amlodipine ($n = 316$) had similar demographic characteristics and levels of comorbidity. A slightly greater percentage of patients started on nifedipine-CC had prescription records consistent with cross-over to a different calcium channel blocker (15.3% versus 10.3%) while a greater percentage of patients started on amlodipine had records consistent with cross-over to another class of anti-hypertensive agent (7.3% versus 13.2%). In adherent patients, other anti-hypertensive drugs were added to each regimen to a similar extent and no differences were found in adverse events that were reported. Total pharmacy costs were determined to be significantly higher ($p < 0.0001$) in patients started on amlodipine ($2536 higher in patients with the most comorbidity to $293 in the least).
CONCLUSIONS: The results suggest these drugs have similar effectiveness and that physicians' drug preferences can have important effects on total pharmacy costs.

TPRD4

THE COST-EFFECTIVENESS OF IMMUNOSUPPRESSIVE THERAPY AFTER RENAL TRANSPLANTATION

Clark T, Shih YCT, Dupuis B, Hartzema A
University of North Carolina School of Pharmacy, Department of Pharmaceutical Policy and Evaluative Science, Chapel Hill, NC, USA

OBJECTIVE: The purpose of this study is to evaluate the cost-effectiveness of the immunosuppressive regimen, cyclosporine, mycophenolate mofetil, and prednisone (CMP), in improving 3-year graft survival in kidney transplant recipients as compared to the immunosuppressive regimen, cyclosporine, azathioprine, and prednisone (CAP).
METHODS: A sample of kidney transplant recipients receiving either cadaveric or living donor transplants in 1996 was selected from the United States Renal Data System (USRDS). Direct costs were estimated from Medicare reimbursements and included: outpatient costs, hospitalization costs due to rejection episodes, infectious complications, or graft failure, dialysis costs due to graft failure, and medication costs. The effectiveness measure was length of graft survival and expressed as the total number of life-months with an intact graft. A Markov model including three Markov states (e.g., graft intact, return to dialysis as a result of graft failure, and death) and two transient states (e.g., graft rejection and complications) was used to model the course of progression and continuous risk of graft rejection. The USRDS data were also used to estimate transplant recipients' transition probabilities throughout the Markov stages.
RESULTS: Although mycophenolate mofetil costs substantially more than azathioprine ($6000 versus $1000 annually), preliminary findings suggest that the CMP regimen is more cost-effective than CAP because of the reduction in hospitalizations and treatment costs saved by avoiding acute graft rejection episodes.
CONCLUSIONS: Our study provides valuable information regarding the most cost-effective immunosuppressive regimen to renal transplant centers. Findings from this study will also be of interest to the Medicare End-Stage Renal Disease (ERSD) program since a majority of the kidney transplant patients were covered under this program.

TPRD5

USING HOSPITAL CLAIMS TO TRACK PRACTICE PATTERNS, OUTCOMES, AND COSTS IN PERCUTANEOUS CORONARY INTERVENTIONS (PCI)

Karweit J, Cascade E, Lin N
The Lewin Group, Fairfax, VA, USA